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ABSTRACT

This monograph about accountability and communication in record keeping is intended for human services professionals. Eight terms are defined in an introductory glossary. The first section discusses the purpose of records. The next section discusses clarity in staff notes. Key points are offered for effective communication through staff notes. The next section focuses on the causes of ineffective communication and on increasing risk exposure. One of the most effective tools for avoiding litigation is utilizing clear communications, particularly for records. The next section analyzes a staff note, noting that a frequent problem is that entries are too short and vague. Learning to write a substantial note in a few sentences is important. Examples of the need for clarity and precision are the focus of the next section. The counselor's written words are the only record of a session with a client, and therefore need to be written accurately. The next section discusses ways of responding to an outside inquiry. Letters responding for outside requests for information demonstrate the counselor's professionalism and expertise. The essentials of the plan of care, care review, and staff notes are considered in the next section. This is followed by analysis of a group note. The next section evaluates a plan of care. Confidentiality and other legal issues are discussed in the next section. The final section provides answers to frequently asked questions. A summary, discussion questions, and references and suggested readings are included. (LLL)

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THE AACD LEGAL SERIES

Volume 2

"DOCUMENTATION IN COUNSELING RECORDS"

Robert W. Mitchell, ACSW

Series Editor
Theodore P. Remley, Jr., JD, PhD

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Counseling and Development

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This book is for every person who has ever tried to help someone. Each of you makes a difference. You always have and you always will.

Special Thanks

To my parents, Isabel and William Mitchell, for teaching me that if something is worth doing, it is worth doing well.

To Carolyn, Debbie, and Rob, my family, for support.

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Robert W. Mitchell, ACSW

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Biographies

Robert W. Mitchell, ACSW, was selected in 1988 as Social Worker of the Year by the Kentucky Chapter of the National Association of Social Workers. He has 31 years of experience in human services, 18 of which were in direct service and supervision. His first job was with Children's Protective Services. He also worked with programs focusing on family problems, chemical dependency, mental retardation, and psychosocial rehabilitation. From 1979 through 1982 he was manager of the accounts receivable department for Seven Counties Services, Inc., one of the nation's largest comprehensive mental health, mental retardation, and substance abuse agencies. From 1982 through 1990 he was also a member of the Institute for Internal Auditors. He is a member of the National Association of Social Workers and a founding member of the American Association for Therapeutic Humor.

A combination of clinical and fiscal experience gives Mr. Mitchell a unique perspective. Since 1981, he has trained over 25,000 human services professionals in 32 states and Canada through his documentation workshop. That workshop, the basis for this monograph, has been sponsored at two national meetings by the National Association of Social Workers Malpractice Insurance Trust and Legal Defense Fund. He has also presented papers at annual conferences of the National Council of Community Mental Health Centers, the International Association of Psychosocial Rehabilitation, the National Association of Social Workers, the

Association of Mental Health Administrators, the Canadian Mental Health Association, and the Institute for Human Behavior.

Theodore P. Remley, Jr., Series Editor, is Executive Director of the American Association for Counseling and Development. Immediately prior to assuming this position, Dr. Remley was chair of the Department of Counselor Education at Mississippi State University in Starkville. He holds a PhD from the Department of Counselor Education at the University of Florida in Gainesville and a JD in law from the Catholic University of America in Washington, DC.

Preface

In 1981, I began giving workshops to human services professionals about accountability and communication in record keeping. Since that time, people have been suggesting that I put the workshop into a book format. What you are about to read is based on more than three decades of experience in the field, including a wide range of clinical and auditing responsibilities as well as consultations with auditors, third-party payers, licensure review teams, medical records personnel, counselors, and lawyers. Some of these professionals had worked for organizations that had gone bankrupt because of insufficient documentation. Printed materials, titled and untitled, also aided in the development of the workshop and this monograph. Although it is impossible to credit each source of information, the monograph contains a list of references and suggested reading materials, some of which influenced the development of this work. When actual records are used, only dates and names have been changed. The text is written in the first person because it is my style, and I want you to know that I am talking to you.

This monograph does not provide a fail-safe solution to all record-keeping problems. Certainly, it is not a substitute for competent legal advice. Ultimately the best records system for you is one you have designed for yourself, your clients, and your agency. But I believe you will find the information useful. You may not agree with everything. Or some things may not be applicable to your work. But one thing is necessary: an acceptance of the need for excellence in record keeping.

Glossary

Client: The recipient of any professional intervention from a counselor. Also referred to as beneficiary, consumer, counselee, member, patient, recipient, and resident.

Confidentiality: Confidentiality, in general terms, means maintaining the secrets of patients and clients, but the concept of confidentiality goes beyond the record and covers communication between the patient and the counselor. The purpose of confidentiality is to encourage candor so that the client yields more thorough information, thereby promoting better diagnosis and treatment. Confidentiality of records also encourages candor in the counselor.

Counselor: The service provider. Includes all professionals, i.e., case managers, educators, nurses, psychiatrists, psychologists, social workers. Also referred to as clinician, practitioner, professional, and therapist.

Plan: A document that details why the client is being served and what is going to be done. Sometimes referred to as an educational plan, individual habilitation plan, plan of care, service plan, or treatment plan.

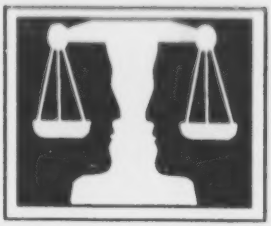
Privileged information: A state statute must specifically identify the communication between a category of professionals and their clients as privileged. Privilege, like confidentiality in general, exists for the benefit of the client and can be waived by the client. There are many exceptions to general rules of

law and ethics. When a judge orders a counselor to answer questions or to provide copies of the counseling record, the orders are absolute unless they are reversed by a higher court or suspended while an appeal is being considered in a higher court. As a result, counselors who comply with a judge's orders cannot be held liable even if someone's legal rights are violated in the process. Counselors who plan to refuse to comply must have their own attorney and must rely on legal advice. Counselors have an ethical responsibility to protest an order issued by a judge if they feel the order violates an ethical obligation. However, if a judge rules the order will stand, a counselor must comply, or may be held in contempt of the court.

Record: Any written documents, audio or video recordings, **or other tangible items** that contain client information. Also any compilation of information for the purpose of diagnosis and treatment. Two items not considered part of the record are incident reports and peer review records.

Service: A generic term referring to professional intervention from the counselor. Also referred to as treatment.

Staff note: A counselor's entry that documents professional judgment or service. Sometimes referred to as clinical entry, daily note, group note, progress note, service log, or weekly summary.



The Purpose of Records

A person can run a red light every day, and the action is of no consequence until the driver hits or kills someone. Inadequate records or incompetent personnel who are responsible for entries in the record may be of no consequence until a malpractice suit is filed or until a funding source demands a payback.

From the first moment of client contact, you, the record-keeping counselor, become responsible and accountable to your profession, the community, clients, the payer, co-workers, and a legal system that protects the rights of each individual. To assume less is unthinkable.

Unfortunately, humans have not been able to develop a system of accountability that eliminates documentation. Thus paper work, the least enjoyable aspect of service delivery, is necessary. In this day of accountability, the content of the clinical entry is becoming increasingly important. Without sufficient documentation, there is no way another counselor can provide appropriate intervention when the assigned professional is not available, no way to confirm the rendering of a payable activity, and no way an agency can defend itself in the event of a malpractice suit.

This monograph is designed solely to assist you in documenting your professional interventions and judgments within the staff note and plan of care. I want to emphasize that I am not attempting to tell you how to serve clients, how to intervene, how to assess a problem, or how to diagnose.

Clear documentation is based on clear communication—which is a two-way process with someone "speaking" (in writing) and someone "listening" (with eyes). Effective communication is important because readers must understand what they read. As counselors, you know how important communication is. You depend on words to help your clients. And, although good communication may prevail during a session, it is often sadly lacking in a record.

Even now, you and I may have a semantics problem. The words I use are based on mental health experience, but the principles are relevant to mental retardation/developmental disabilities, substance abuse, and psychosocial rehabilitation. I may say *treatment*, but you may say *service*. Or I may say *therapist*, but you may say *counselor*. I may say *client*, but you may say *consumer*, *recipient*, *beneficiary*, or whatever. Each reader is a professional with a professional lexicon.

I frequently hear practitioners complain that the purpose of recording has become distorted. They say that initially the record was intended as a treatment document, but now it seems to be a tool for billing. To some extent that is true. However, although a thousand services a month, with the greatest treatment technique, may be of tremendous value to the community, if you are to continue to meet human needs, you must also create a legally and fiscally accountable chart.

Some people say, "Human needs come first: Our only concern is the delivery of service." According to this contention, paper work has nothing to do with the quality of care or outcome. On the contrary: Paper work, which represents quality record keeping, is a legitimate concern for the professional. We cannot expect society simply to hand over the funding and provide us with unlimited legal protection just because "we do good." Yes, the record is a treatment tool; but it is also a legal document. There is no sense in trying to deny this; it is the way things are. If your note or plan is illegible, vague, or missing, you fail to provide accountability and confirmation of good treatment.

You can never argue that you are the only one who will see a record. It is possible that the record will be seen by your supervisor, a program director, an auditor, another therapist, an attorney, and the client.

Yes, the client. Writing notes and treatment plans with a client can become an integral part of service delivery. Records

provide the structure and focus for future interviews as well as essential continuity, whether you are seeing the client or someone else is seeing the client in an emergency. Don't clients have a right to know what is in their records? The courts seem to be saying that they do. More and more, clients are being made aware of the fact that they have a right to the record's contents. If you are not already doing so, remind clients that when they sign their permission-to-treat forms, their records may be reviewed by people other than yourself.

Encourage the client to help you write the record. Involvement with the client helps demystify the record. My clients experienced a sense of gratitude and relief. Most clients know something is written down; they just never know what. To know that something is written down and not have any idea what that "something" is can produce anxiety or inhibition. That, in turn, can adversely affect your relationship.

Often, client discontent lies behind a malpractice suit. One possible way to keep a client satisfied is to involve him or her in the documentation process. In addition, clients may be less likely to subpoena a record and manipulate its contents if the contents are known to them or are their own words.

In some malpractice suits clients contend that a counselor:

- "gave bad advice . . . told me to do such and so . . ."
- or "did not fully explain to me . . ."
- or "never talked about that!"
- or "did not even mention side effects of my medication."

What would your words document? Would they assure that you are accountable?

Accountability is a concept that has become more prominent, due in large part to a demand for some indication that the money's worth was obtained. Because our activities often depend on public funding, some accounting is required. You must adhere to the golden rule: Those who have the gold make the rules and can change them at any time! Funding sources are very cost conscious and unsympathetic to unsupported claims. Third-party payers have a right to demand that our records verify services for which we receive reimbursement.

If credible, professional accountability is to occur, we must view our service as an incidence of a definable activity. Systematic evaluation requires us to be able to state goals in objective,

measurable terms. To provide anything less leaves us open to accusations of ineffectiveness or fraud. We do not deserve that, but inadequate records can give others an opportunity to doubt and question the validity of our intervention. The argument that "some good was done" is worth very little if the good is not documented. Funding sources may lose confidence in what they are being asked to pay for; and if an attorney should scrutinize a record, an agency may appear to be staffed with incompetent workers who should be sued.

Let others clearly know what you do and that it is worthwhile. Such statements can and should be simple and direct. For some reason, however, a human tendency is to complicate things on paper. This kind of communication problem touches every profession. Consider, for example, the plumber who wrote to the U.S. Bureau of Standards. "Is it safe to use hydrochloric acid to open a clogged drain?" he asked. The reply gave this advice: "The efficacy of hydrochloric acid is indisputable, but the corrosive residue is incompatible with metallic permanence. Suggest you use some alternative procedure." The plumber then wrote back saying, "I don't understand." Whereupon the bureau offered this clarification: "Don't use hydrochloric acid. It eats hell out of pipes!"

In our work, there is a clear mandate to prove we did something. Therefore, as competition for available revenue increases along with malpractice lawsuits, we can no longer afford to be lax in documentation. Counselors usually interpret information logically, but when they write, they are not always as logical or specific. If distortion and confusion are to be eliminated, there must be a mutually agreed upon purpose, understandable vocabulary, and specificity.

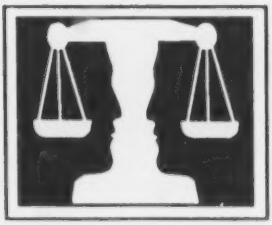
Let's consider the record's purpose. Who uses a record and why? Most users are in-house professionals. The assigned clinician uses it to assure continuity and adhere to an established treatment plan. A co-worker may be required to provide emergency service because the assigned therapist is out of town, on sick leave, or no longer with the agency. Therefore, a record must let any reader know why the client was seen, what services were given, and what needs to be done. Clinical supervisors use a record to review a counselor's professional growth, use of time, and adherence to a plan. Other users include research and evaluation staff or utilization review teams. They evaluate the ap-

propriateness and quality of service, examine program effectiveness, and determine the need (or lack of) for continued service.

Not all users, however, are concerned with in-house monitoring. Some of the most "dreaded" users of the record are auditors. Their use of the chart is necessary to determine a level of compliance with licensure or payer regulations. Their concerns include, but are not limited to, client eligibility, verification of a need for the billed services, a current plan of care, and the type of professional who gave service. Their job is to answer the question, "Does the content substantiate a reimbursable service as defined by the payer?"

Other more ominous questions may be asked by attorneys, who are also among the most dreaded users. From our perspective, attorneys' use of a chart usually seems negative and threatening. Attorneys may challenge the record's credibility and make every effort to confirm agency guilt. An attorney may attempt to establish a reasonable doubt with your words—or your lack of words: White-out on the record suggests changes; out-of-sequence notes suggest alteration. Any missing, incomplete, changed, or wrong dates create doubt. Meaningless notes suggest incompetence. Conflicting information produces concern about staff ability or concern for the client.

The record must be a precise reflection of the service, treatment goals, and achievement (if any). Accurate staff notes and treatment plans go a long way in establishing responsible accountable activity. If your writing is vague, it is of limited, if any, value. Usefulness requires specificity.



Clarity in Staff Notes

A frequent complaint is "I spend too much time writing staff notes." We need to learn to write less and say more. Analyzing and rewriting the following actual note, taken from an actual service record, will illustrate:

(Date) I had session with client today at office. Client's affect was flat and was s/w non-verbal at times. Client and I talked about the letter she had left for me at the office. It seems that client has written letter out of depression with possible suicidal ideation present. Client and I talked about some ways she could deal with negative feelings she has about herself. I asked client if she had a suicidal plan—client did not. Client stated she doesn't want to harm herself but she feels empty, worthless. Client and I talked about her relationship with others and her daily activities. Client seems satisfied with present activities but concluded she would like to become more involved in arts and crafts, as she is extremely talented. I suggested to client she research what's available in the way of arts and crafts and possibly enroll herself. Client stated she felt much better after having wrote the letter to me and also in talking with me today. Client seemed to be much more relaxed and seemed to smile easily. I praised client for her honesty and her trust in me. I urged client to contact me at any time, day or night—client and I too discussed what she feels is compulsive spend-

ing. I suggested to client she contact the Crisis Line to inquire whether or not there is a support group for compulsive spenders. However, in my opinion, I suspect client has been spending because of her depression. Client and I will set up an appointment as soon as possible.

Analysis

I had session with client today at office. Only one word in this sentence has possible relevance: *office* (which tells us where the service occurred). Look for ways to eliminate words.

Client's affect was flat and was s/w non-verbal at times. Abbreviations such as *s/w* for *somewhat* can and should be used to help you maximize effective use of your time. However, it is important that everyone within an organization uses the same abbreviations to mean the same things and recognizes meanings of abbreviations can change. For a record to be an effective tool for communication, there must be a mutually understandable vocabulary. The word *nonverbal* is contradicted within the context of the remaining note, i.e., there are frequent references to "client and I talk about . . ."

Client and I talked about the letter she had left for me at the office. There should be more specific references to the content and the location of that letter.

It seems that client had written letter out of depression with possible suicidal ideation present. The word *seems* causes doubt. As often as possible, eliminate words like *seems* or *appears.* If, in your professional judgment, you must use a qualifier, then explain it with words such as *as evidenced by* . . . The word choice in the sentence is also questionable. Be more specific about *suicidal ideation.* When tied to other sentences, one could begin to question the competence of the provider's ability to be entrusted with the life of a troubled person.

Client and I talked about some ways she could deal with negative feelings she has about herself. Three words can be replaced with one, i.e., *client and I* can become *we.* What *ways* were discussed? What *negative feelings* does this client have? If you use an adjective, such as *negative*, define it. If the phrase has been defined in another part of the record, an entry becomes more useful. If it has not, such a phrase becomes an unfounded opinion.

I asked client if she had a suicidal plan—client did not. This is useful information.

Client stated she doesn't want to harm herself but she feels empty, worthless. These words contain useful information, but its source is ambiguous. Did the client use the words *empty, worthless*, or is this the counselor's opinion?

Client and I talked about her relationship with others and her daily activities. This could be a critical part of the interview, or it could be an everyday conversation. What *relationships*? What *daily activities*? Are these activities that she has been avoiding or that she has been involved in? If this information is not pertinent to her treatment, do not include it. If the information is important, be more specific.

Client seems satisfied with present activities but concluded she would like to become more involved in arts and crafts, as she is extremely talented. The word *seems* causes this entry to lose its clinical usefulness. What significance is there in satisfaction or lack of it? If this kind of information relates to a plan, it could have meaning. If not, it is useless and wastes words. Who said she is *extremely talented*? Is this the client's opinion of herself? What value is this information?

One of the most frequent complaints from record reviewers is that when they read a plan and the subsequent notes, they don't know they are reading about the same person. If a level of satisfaction is important, eliminate the doubt by using the client's own words, i.e., "*I haven't been as satisfied in years*" or "*I haven't felt as comfortable around people in a long time.*" Using the client's words not only eliminates doubt but also provides the reader with a more accurate picture of what the counselor dealt with.

I suggested to client she research what's available in the way of arts and crafts and possibly enroll herself. This places the burden of *research* on the client, who may not know where to begin and who is already feeling inept. An attorney might question the reasonableness of having a potentially suicidal client doing the research. Remember, our records are of use to a malpractice attorney only insofar as they contribute to a settlement for the plaintiff. What does *possibly enroll herself* mean?

Client stated she felt much better after having wrote the letter to me and also in talking with me today. This grammatically incorrect sentence causes the reader to wonder about the writer's professional qualifications.

Client seemed to be much more relaxed and seemed to smile easily. Who cares? Does this have anything to do with the plan of care? If yes, it could be pertinent. However, the use of two qualifiers causes the reader to wonder about the capabilities of the provider to make observations and draw appropriate conclusions for the direction of subsequent services. Again, why not use the client's words? They will eliminate the doubt and make a much stronger entry.

I praised client for her honesty and trust in me. Is this significant? Is it necessary? Or is it perhaps just an ego trip for the practitioner?

I urged client to contact me at anytime, day or night—client and I too discussed what she feels is compulsive spending. These are two sentences and should be punctuated as such. More seriously, this sentence opens the possibility of legal problems. Many times we make promises we cannot keep. In this instance, it may or may not be appropriate to be available 24 hours a day. How vulnerable are we if the client attempts to phone the therapist and can not make contact? She may commit suicide and leave a note saying, "I tried to call my counselor; no one answered. No one cares." When the husband takes us to court, how vulnerable are we? No one can say for sure, but I doubt this note will help us.

A reader would be confused by this kind of note because there is no organization or logic. If we discussed compulsive spending, what did we say? What is our specific intervention?

I suggested to client that she contact the Crisis Line to inquire whether or not there is a support group for compulsive spenders. Once again, responsibility has been placed upon the suicidal client. Will other components of this record indicate that we have, perhaps, given this individual too much responsibility and that, in turn, this may have caused her to attempt suicide later in the evening?

However, in my opinion, I suspect client has been spending because of her depression. Opinions can make a powerful entry and verify the fact that we are professionals. Opinions, however, should be clearly acknowledged as such, and their source indicated.

Client and I will set up an appointment as soon as possible. An appointment is necessary but the date and time must be specific. That is not only good service but also good documentation.

Rewrites

The preceding analysis highlights possible problems, both substantive and structural, in writing a staff note. The following rewrites show you how to reduce the number of words and provide any reader with more useful information:

I.

(Date) Crisis intervention. Client said she felt empty and worthless. Affect was flat and she was occasionally nonverbal. We discussed a letter she wrote in state of depression. The letter indicated suicidal ideation, but client says she does not have a plan and does not want to harm herself. Following our talk, she verbalized feeling better, confirmed by smile. She expressed a desire to become involved in arts and crafts and with encouragement she agreed to explore opportunities. We also discussed her compulsive spending, which I believe is prompted by the depression. She was referred to the crisis and information center regarding a support group. I supported her ability to talk through problems. See again on (date).

II.

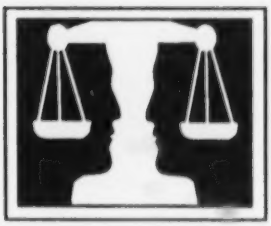
(Date) Individual session: She had written a letter to me indicating suicidal ideation. On questioning, she revealed depression and low self-esteem, but no suicidal intent or plan. Client was less depressed and smiled at the end of the session. She was told to call me tomorrow. She was also given the phone number of emergency services and told to call any time if she felt suicidal again. See again on (date).

Key Points

In writing staff notes remember to:

- Make notes grammatically clear and correct.
- Use precise language; reduce the potential for misinterpretation.

- Use only adjectives that are defined, necessary, and clinically appropriate; when possible, replace an adjective with a verb that describes behavior.
- Avoid clichés like the plague!



Ineffective Communication and Legal Trends

This section focuses on the causes of ineffective communication and on increasing risk exposure. Since 1981, the number of malpractice suits as well as the settlement amounts have increased yearly. This indicates that human services professionals must concentrate their efforts on avoiding litigation—and one of the most effective tools for this purpose is utilizing clear communications, particularly for records.

What precisely constitutes a record? Records of any type are amalgamations of information—history, observations, examinations, diagnoses, consultations—that relate to a patient's current and previous care. They are compiled by health care professionals for the purpose of diagnosis and treatment of clients. They include financial and social information as well as practitioner observations about a client.

Items considered part of the record include:

- all reports pertaining to a client's care by the provider
- reports originating from orders written within the facility for tests done elsewhere
- client instruction sheets
- forms documenting emergency treatment, stabilization, and transfer.

Some items filed with a record may not, however, be part of the record. These include:

- ambulance records
- correspondence
- incident reports
- peer review records.

Ineffective communication—that is, the lack of clear documentation—within a service record can produce serious problems. Such a lack can, for example, greatly contribute to the client's case if a malpractice suit is filed. And if an agency loses a malpractice suit, the costs can be a loss of credibility, bad publicity, and increased insurance premiums. Insubstantial, ineffective documentation in counseling records can cost an organization in other ways, too. For example, a third-party payer could demand payback of funds already received by the agency.

Juries across the country are proving with each malpractice suit that their sympathies lie with the client. Juries tend not to believe a counselor who claims he or she can "remember" what happened in a session conducted in previous years. Without adequate documentation, your credibility is damaged and professionalism can easily be called into question.

Already, courts across the country are setting precedents in mental health cases. For example:

- California courts ruled that the public good outweighs the individual good.
- In *Tarasoff v. Board of Regents* (1976), it was determined that client confidentiality is not sufficient reason to absolve clinical responsibility. In other words, not reporting potential danger is considered "inaction," and the therapist or agency may be held responsible.
- In *Hedlind v. Superior*, the court decided that failure to warn the potential victim is not only simple negligence but also a professional negligence. Any other person whose life or safety is affected, if not notified, has grounds for a lawsuit. In other words, a "reasonably foreseeable victim" can sue you.
- In *Jablonski v. U.S.A.* (1983), the Veteran's Hospital administration was found to be negligent because admin-

istrators did not consult their own records, which clearly documented a history of violent behavior.

Malpractice suits are changing the traditional definition of *confidentiality*, and suits that call into question treatment or diagnoses are becoming more common each year. It is in such cases that accurate, concise documentation—that is, effective communication—can spell the difference between a favorable or unfavorable decision.

Effective communication can, of course, be difficult to achieve. Even when you think you've made yourself clear, it is possible not everyone will understand. In some instances, haste, excitement, or lack of attention can contribute to sentences that, though basically accurate, leave the reader with an entirely wrong impression.

To illustrate, listen to how five drivers describe their accidents. These explanations are said to be from actual reports.

Driver 1: I had been driving for 10 years—when I fell asleep at the wheel and had an accident.

Driver 2: The pedestrian had not planned which way to run—so I ran over him.

Driver 3: I saw a slow-moving, sad-faced old gentleman as he bounced off the roof of my car.

Driver 4: Coming home, I drove into the wrong house and hit a tree I don't have.

Driver 5: The guy was all over the road—I had to swerve a number of times before I hit him.

In each case, the driver, in his or her mind, was quite accurate in the assessment of the accident but phrased it in such a way that he or she appeared less than capable.

No one, it seems, is immune to making mistakes in either writing or speaking because words can be so tricky. If there is no mutually shared vocabulary, there is no understanding and communication is ineffective.

Let's consider the type of information important for effective communication in treatment planning by looking at a hypothetical case study:

The clinical rating scales are an immediate result of her belief in the importance of integrating multiple measures. In this instance, two global scales, that is to say, the Level

of Functioning Scale of Carter and Newman in 1976 and a global psychopathology index, specifically proactive interventions such as those which occur before an event happens. Anticipatory dialogue is one useful clinical approach when the principal time frame aimed at either strengthening the individual or reacting effectively follows the occurrence of a nonpredictable event or specific stressor, for which no preparations were rendered. The treatment of choice is, therefore, obvious.

As you can see, there is no way to translate this kind of language. Failing to communicate properly can adversely affect the continuity of service and can also provide an attorney with good evidence to build a solid case against you or your agency. We have probably all been guilty of pretending to understand for fear of being ridiculed. The chances are excellent that if you do not understand, it is not understandable. Asking for clearer information saves time later and contributes less confusion and better understanding.

Another reason effective communication can be difficult to achieve is the nature of language itself. Very often, one word can have several meanings. The word *bad*, for example, can mean either *naughty* (which is negative) or *cool* (which is positive). Two people can, and often do, look at the same behavior but describe it differently. Consider the following exchange:

Woman 1: I can't believe he said that to me! He told me I was pushy!
Woman 2: If you'd been a man, he would have said you were assertive.
Woman 1: Yeah, it all depends on what you are! A man is friendly but a woman is a flirt.
Woman 2: A man "thinks," but a woman "wastes time."
Woman 1: A man has a temper . . .
Woman 2: . . . but a woman is bitchy!
Woman 1: A man takes an interest in his employee's problems
Woman 2: . . . but a woman is a gossip!
Woman 1: A man gets depressed . . .
Woman 2: . . . but a woman is suffering from "that time of the month"!
Woman 1: A man is independent . . .

Both women: . . . but a woman is a feminist—a bra burner!

This conversation shows how prejudice can influence a choice of words.

Thus, to recap, ineffective communication has several causes:

1. **Oversimplifying** allows someone else to draw conclusions from too little information or from vague generalities. If you use a word that can have several meanings, you must clarify.
2. **Speaking, or writing, without thinking first** can cause embarrassment and disaster. As noted with the accident drivers, their retelling of the accident left us with the feeling that they should never have been allowed to drive at all.
3. **Allowing your prejudices or opinions to color your choice of adjectives** can equate to vague, unsubstantiated judgments. Lawyers refer to such words as unfounded and conclusionary.
4. **Using too much technical professional jargon** can be confusing since two groups of professionals often disagree about "true definitions."

Yet another cause of ineffective communication is that we tend to take our words for granted, believing that another professional will always be able to understand precisely the point we want to make. Attorneys, judges, juries, and clients may be forced to read between the lines. And such reading between the lines can contribute to serious problems with third-party payers, auditors, and attorneys.

The old saying that an ounce of prevention is worth a pound of cure is well worth remembering: It is usually impossible to take back what you have written. Ill-used words can haunt you and your agency for years to come.

Note also that punctuation marks affect understanding. For example, read this sentence: "Woman without her man is a savage." Now read the same sentence, punctuated as follows: "Woman: without her, man is a savage." See what I mean!

In working toward effective, accurate communication, consider the following points:

- Research shows it takes longer to understand a negative statement. As often as possible use a positive mode. However, the rule must be tempered because there are times when a negative statement does a better job.

- Writing is said to be 80 to 90% listening. Our training has taught us to be good listeners, so why not write it the way you hear it? Direct quotations can be useful, but be careful: Direct quotes must be the exact words of the speaker.
- Paper work takes time to produce and to read, so eliminate unnecessary words. Brevity and precision will save time and enhance clarity for you and your reader. For example, write:

  prefers instead of *shows a preference for*
  fewer instead of *fewer in numbers*
  indicates instead of *gives an indication of*
  prolong instead of *prolongs the duration*
  agreed instead of *generally agreed upon*
  needs instead of *has a requirement for*
  cooperation instead of *mutual cooperation*
  immediately instead of *without further delay*
  please instead of *I would appreciate it if you would.*

Your professional judgments must be supported. We are usually criticized for not providing enough information. Even though we write many words, sometimes we don't say much. Many records remind me of the horns of a steer: You know, a point here, a point there . . . and a lot a bull in between! Don't write *Wayne is cruel.* Write *Wayne hits his sister with a ruler.* Do not label a parent as *unfit.* Describe the behavior that caused you to reach that decision.

If, for example, a plan lists an objective such as *eliminate primitive behaviors,* will a reader know what that means? Imagine the client saying, "Watch me eliminate my primitive behaviors." What would you see or hear? That's what needs to be entered into a chart.

When an objective is to *develop meaningful interactions,* what does that mean? If your client said, "Watch me develop meaningful interactions!" what would you see? What would you hear? Enter the specific behavior.

Speaking to the National Association of Social Workers several years ago, former NBC newscaster Edwin Newman (1987) warned that "A nation awash in jargon and illiteracy is not healthy. If the level of our language usage declines, we decline

with it." He went on to say that too many professions have adopted jargon that groans with false dignity and obscure meaning. He concluded his remarks saying, "The public needs to have confidence in you, to have realistic expectations of what you can do. Wrapping yourself in jargon unnecessarily cuts you off from other people. Be specific, be concrete, and be direct to get the public on your side."

Analysis of a Staff Note

A frequent problem is that entries are too short and vague. Learning to write a substantial note in a few sentences is important. Unless you have an unusual situation, most notes can be done within 10 sentences. As we saw in the Clarity in Staff Notes section, less can be better; but brevity must contain substance, as the following example of an actual staff note illustrates:

> (Date) Client attended the party. He socialized with others and seemed to be having a nice time. However, during the latter part of the party, I found the client sitting on steps (outside of party) sulking with a scowl on his face. I asked client what had happened, he refused to say. I tried numerous times to find out what was troubling client, but he would only state he "would rather not talk about it." I told client I would contact him tomorrow, client shook his head OK.

Analysis

Client attended the party. Activity alone is never sufficient reason to expect a funding source to provide reimbursement. There must be service as defined by the payer. The fact that someone walks into a building is never sufficient reason to expect continued funding. In most instances, counselors reach out, support, or encourage. They do not let people sit or simply *attend* a party. There must be

participation or there is no service. A note must document the level of participation and specific clinical interventions.

What kind of party? Why should anyone pay us because a client *attended a party*? In all likelihood this was a resocialization group; however, we did not document that. Notes like this shortchange us.

He socialized with others and seemed to be having a nice time. How did he socialize? What is the significance? *Seemed* to be having a nice time? Who cares? What is the clinical implication, if any? If it is significant, why not use the client's own words, i.e., "I haven't had such a good time in years. I feel alive again." Document behavior and tie your words to the plan of care.

However, during the latter part of the party, I found client sitting on steps (outside of party) sulking with a scowl on his face. What is the *latter part*? What is the significance? *Sulking* and *scowl* have negative connotations. Can we assume that these are accurate? What is the clinical significance of these adjectives? Are they necessary?

I asked client what had happened, he refused to say. The word *refused* indicates the writer knows that the client made a deliberate and conscious decision not to share information. Can we assume that this is an accurate statement? Is it possible that the client, for no explainable reason, simply wanted to be alone? Haven't you experienced that sensation? Two sentences here would be better.

I tried numerous times to find out what was troubling the client, but he would only state he "would rather not talk about it." How many is *numerous*? How did the counselor attempt to find out? The word *troubling* also implies either clinical knowledge or an unfounded opinion. Which is it? A note needs to clarify these issues.

I told client I would contact him tomorrow, client shook his head OK. What is the significance of the client's shaking his head? This entire sentence could be replaced with two words: *See tomorrow.*

Rewrites

There are many ways to write an effective note. Here are two examples that are still brief but also contain useful information:

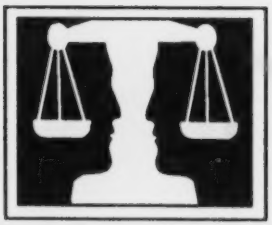
I.

Group. For the first 15 minutes, client spoke with several friends and was seen laughing. Since his tendency is to isolate himself, this is progress. I encouraged his efforts to initiate conversations, and he said, "It's hard, but I'll try." Later I found him sitting alone on the porch steps. I was unable to determine a reason for his withdrawal. He said, "I'd rather not talk about it," so we sat in silence. Before returning to group, I assured him that some periods of isolation are healthy but explained total isolation could be harmful. He acknowledged with a nod and smile. See on (date).

II.

Client was able to talk with other participants for about an hour at the center-sponsored social activity. Later he became withdrawn and was encouraged to speak with me but did not do so. He has improved, however, in that with support he is able to spend 30 minutes longer socializing with his peers than 1 month ago. I will contact him next week and provide support prior to Friday's scheduled activity.

The first rewrite is only two sentences longer than the original, and the second rewrite is actually two sentences shorter. Both, however, give more useful information.



Factors Vital to Clarity

Mark Twain once said to would-be writers, "As to the adjective, leave it out." His words have meaning to us today. He meant that when you write an adjective, for better or for worse you give an opinion. As indicated in earlier sections, adjectives must be carefully chosen, or even replaced, if the language is to be clear and precise.

Examples of the need for clarity and precision are the focus of this section. Your written words are the only record of a session you have with a client, and those will count for nothing, for your agency's purposes or in a courtroom, if you have not written them down accurately. Let's take an example: The sky is blue . . . no, the sky is generally blue . . . no, the sky generally appears to be blue . . . no, in some parts of the world, what is generally thought of as the sky sometimes appears to be blue. We sometimes make things harder on ourselves when we go to extremes. All we need to say is the *sky is blue*. In many instances, the work we do is simple and very straightforward; we don't need to mystify it with complicated or confusing words.

Here's another example: *Jerry is exhibiting signs of depression*, or *Jerry is depressed*. These sentences are grammatically correct, yet I am unsure what exactly is meant. An attorney would have a great time with either of those statements, saying the writer was judgmental, prejudiced. The client was simply a quiet, unassuming person whose behavior produced unwarranted and false conclusions. To eliminate that possibility, all you need to do is add a

simple clarifying phrase. If Jerry is depressed or showing depression, add something like *because he lost his job.* If Jerry is depressing his emotions, add *by not answering questions, and by changing the subject.* What clues tell you Jerry is depressed? Add *He said he has not been able to eat or sleep, and is concerned about the crying spells.* Now your conclusions are supported with specifics.

Let's consider more examples:

- A favorite, but inadequate, phrase in records is *negative attitude.* Again, that is too vague and too judgmental. To make it clear, write something like *learn to discuss problems instead of throwing things.*
- A frequent goal is *improve hygiene.* That's too vague because it doesn't tell you enough of a story. You must be specific. How about *Brush teeth and shower each day*?
- Don't write *Learn to become more independent.* What does that mean? Set up a business? Leave a husband? The specific goal could be *Get up in the morning and report to job on time.*
- *Increase self-esteem* is another favorite goal, but it's difficult to really sink one's teeth into such a phrase. How about *Will not be critical of self or personal decisions about disciplining children.* See the difference?
- The record may read *Client participated in chalk talk.* What does *participated* mean? Will every reader understand that a *chalk talk* is a chemical dependency lecture? Did the client talk? Cry? Take a swing at another client? Or at you? Someone can participate in an active or a passive way. So one word doesn't tell much. To clarify *participate*, add *client revealed examples of how he had fooled himself about the increasing use of drugs. He reported denying the importance of wife's complaints. The group encouraged his willingness to open up.*
- Since part of our topic concerns communication, let's take the phrase *communication problem.* Again, what does this mean? Why not list the problem exactly: stuttering, speaking too fast, or talking around the subject.
- Is your client withdrawn? How do you know that? Write instead *Suzanne is withdrawn as evidenced by the fact that she spends all her time in her room and refuses to even eat meals with her family.*

- To characterize someone as *aggressive* is not enough. Does the client fight? push? scream? kick? Do not leave room for interpretation. If the client described eventually takes you to court, the term *aggressive* used alone could be interpreted by the attorney as a positive characteristic, not a negative one.
- If a client is unemployed, there may be more to the situation. Clarify your entry by adding something like *has been fired from last three jobs for drinking and excessive absences.*
- You can define the term *nervous* by writing something like *not eating, sleep is not restful,* or *screams at children.*
- Instead of *feels bad,* write *history of high blood pressure and heart condition.* Remember, one can feel bad physically and/or emotionally. That holds true for another one-word problem: *health.* Enter something like *asthmatic condition requires expensive medication, so client does without.*
- When the client is ambivalent, you need to know why. So does a record user. Enter something like *She cannot make a decision about continuing in a marriage with abusive spouse.*
- We often think we are describing a behavior when we say *Henry is lazy* or *Laura is aggressive* or *Karen is withdrawn.* These statements do not describe behaviors; they make undefined judgmental observations. That could be disastrous for a counselor and the agency. What characteristics or symptoms give you cause to think the way you do? Write them down!

As you are choosing words, remember it is a complex task. Your choice could convey, deliberately or not, a view that tends to be too negative. Consider these examples and decide which is better: *dumb* or *limited intelligence*; *cheap* or *economical.* **It is vital that your words be clear and precise to satisfy your profession, external auditors, your client, and attorneys, should the need arise. It is necessary to substantiate your observations and give them authority. Remember, good entries are precise and current.**

There is also the matter of timeliness. The word *current* is a directive to record information immediately! Waiting even 1 day

can blur accuracy. Those who wait until the last minute to write their entries often suffer from fainting spells, anxiety attacks, and acute writer's elbow—a heavy price to pay.

Your client should be an active participant in setting goals and writing staff notes and plans. Document client participation, perhaps including the client signature. Set goals the client will understand, agree with, and accept. Objectives must be specific, measurable, and meaningful to the client. Set a date for achievement of those goals. Define the methodology to be used in goal achievement. Do not create a reasonable doubt; that's a lawyer's job! Using words that are not specific or that create vague impressions could equate to an opinion, leaving room for reasonable doubt and the possible destruction of your credibility.

The writer's reasonableness and credibility can be assumed not only from the words but also from the readability and appearance of the overall chart. Did you ever stop to think a record's appearance affects a reader just as the appearance of a speaker affects a listener? There are several major factors that will influence the written word's credibility—and clarity:

- **Legibility.** Scrawled, scratchy, or sloppy handwriting, which is difficult or impossible to read, may make the writer appear irresponsible, fairly or unfairly.
- **Spacing.** Small writing that is crammed into a small space not only says something about the writer's concept of what is important but also frustrates the reader who may already be looking for a way to use the record against you.
- **Format.** Disorganized filing, half-completed forms, and a rambling assortment of ideas leave too much room for doubt.

Not taking care of the appearance of a document may be construed as an indication of disregard for the client and a lapse in professional accountability.

Responding to an Outside Inquiry

Record keeping is a skill. The ability to communicate in writing is an essential part of our professional expertise. It involves clinical judgment and permits you or any other person in the service system to make fully informed decisions and to act responsibly. Unfortunately, good practice is not always documented. I doubt that we are ever going to love record keeping, but I believe the process can be made less burdensome. If you link your record's content more closely with the plan, you also increase quality. A record's content can demonstrate deep understanding and commitment to the client. When you select information to be included, you should be guided primarily by the purpose of serving the client, and the client is served best by records that are clear and precise. This is equally true when that information is requested by outside sources. How to deal with that is the subject of this section.

Analyzing and rewriting the following letter to a spouse abuse center, an actual response to an outside request for information, will illustrate:

Dear Mrs. J:

I am writing in response to your request for information regarding Diane. Diane was first seen at this center on January 22, 1989, and was given a diagnosis of major depression

and prescribed Doxpin, an antidepressant medication. During this initial session, she appeared depressed, confused, and totally overwhelmed by her numerous life stressors. She exhibited poor coping skills, low self-esteem, and probable low intellectual functioning. It was recommended that she continue to take medication and begin weekly therapy sessions.

Diane has been seen only once since her initial session but has made numerous phone calls to schedule and cancel appointments. A more thorough assessment is not possible at this time unless Diane chooses to resume treatment. If further information is needed, feel free to call me at 1-918-9898.

Analysis

I am writing in response to your request for information regarding Diane. Was the request verbal or in writing? Do we have the client's written permission to release the information? Did the writer provide information in response to a specific request, or is the information something the writer assumed might be useful to the spouse abuse center?

Make writing easy on yourself! Find out the specific information that is required and provide only that information. Do not spend your time reviewing a record and sorting through information that may or may not be useful to another organization.

Diane was first seen at this center on January 22, 1989, and was given a diagnosis of major depression and prescribed Doxpin. Was she seen voluntarily or as the result of a court order? Who made a diagnosis of major depression?

Doxepin is misspelled. Spelling is still important. A letter is a visible expression of you and your agency's professionalism. Proofread all letters.

During this initial session, she appeared depressed, confused, and totally overwhelmed by her numerous life stressors. If the client appeared *depressed, confused, and totally overwhelmed,* what was the evidence? Specify the behaviors that caused you to reach such a conclusion. How many is *numerous*? There are many kinds of life stressors. Which ones?

She exhibited poor coping skills, low self-esteem, and probable low intellectual functioning. What coping skills? There are many

kinds. Was the low self-esteem the client's description of herself, or is it the writer's opinion? What is *probable low intellectual functioning*? We must be specific.

It was recommended that she continue to take medication and begin weekly therapy sessions. This is significant information. What was Diane's response?

Diane has been seen only once since her initial session but has made numerous phone calls to schedule and cancel appointments. How much time transpired between first and second visits? How many is *numerous* phone calls? What was our response? Specify how many scheduled and how many canceled appointments.

A more thorough assessment is not possible at this time unless Diane chooses to resume treatment. A *more thorough assessment*? The assessment provided is not even thorough. Are we going to reach out or are we going to close the case?

If further information is needed, feel free to call me at 1-918-9898. The previous sentence indicated that we were unable to provide more information and yet we are offering it.

Rewrite

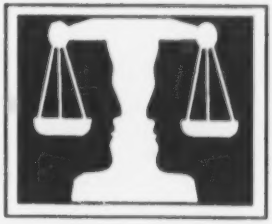
There are many ways in which a clinical entry can be written. There is no one right or bulletproof system of record keeping. Nevertheless, here is a rewrite for your consideration:

> Dear Mrs. J:
>
> Thank you for referring Diane. We appreciate your confidence and look forward to a continuing relationship with the Spouse Abuse Center.
>
> Diane was seen on January 22 and 30, 1989. She said that she did not want to discuss her problems, and although she phoned to make four appointments, she did not keep them. In addition, Diane has not returned our phone calls or responded to two letters urging her to come in. Her diagnosis was major depression. She was given a prescription for Doxepin and urged to see us on a daily basis. Our multidisciplinary treatment team felt that she was a danger to herself because she mentioned suicidal thoughts and she had been hospitalized in July of 1988 following a suicide attempt. We recommend close monitoring.

This letter is also to advise you that in accordance with agency policy, Diane's case will be closed if she does not return to therapy by June 30, 1989. In conclusion, we request that you assure Diane of our continuing interest in her welfare. She can return at any future date, and the regional hotline is always an available resource.

(Signature)

Letters responding to outside requests for information require special care and accuracy. Perhaps even more than internal documents, they must demonstrate your professionalism and expertise. Therefore, they must meticulously reflect the original documents cited.



The Essentials of the Plan, Review, and Note

Records are not only treatment tools but also source documents that reflect your professional skills. They need to clearly document a need for and the rendering of quality services. Style does not have to be stagnant. Let your creative genius come alive! Become a painter. Catch the feeling rather than mere surface details. Then you can feel good about yourself, your service, and your documentation. Remember: There is no need to go overboard; you are not being asked to write the next great American novel, but you are being asked to be aware of what writers call good diction, the right words for the right purpose.

Let's start by reviewing the full text of inadequate staff notes. For example:

- Client in to watch TV, no interaction.
- Status quo. Medication refilled.
- Seemed anxious and jumpy said mother wanted to see me.
- He sleeps all day and not actively looking for work, thinks he can get back his wife.
- We baked chocolate chip cookies.
- Jamie stared at the floor. Would not lift her head.

These words or other brief observations of this type may convey clinical knowledge, but if so, it is too subtle. Someone who is not familiar with the case can only assume clinical significance from such statements, which are only brief descriptions of a condition or an opinion. Clinical entries must *prove* clinical significance. The essential elements for effective clinical entries are:

- specific words that clearly document services as related to goal and diagnosis
- specific words that confirm interaction and/or intervention between counselor and client
- specific reference to client reaction, attitude, and symptoms
- specific mention of progress or lack of progress.

We're not the only ones who use words that fail to make our message clear. Clients have the same problem, as this one-sentence letter to a welfare department shows: "In accordance with your instructions, I have given birth to twins in the enclosed envelope."

You need to protect your client, your organization, your profession, and yourself. Consider what might happen if:

1. I wait 24 hours or more to write the entry, but by then I have forgotten crucial information.
2. The client reads what I write.
3. Someone else has to read and understand what I wrote because I am sick and there is an emergency.
4. This entry is the one that will be selected by the state site visit team, and my words must verify a service as defined by the payer.
5. The record is going to be subpoenaed, and I am going to be called as a witness. Worse yet, someone else is going to be called as a witness to interpret my record.
6. In court, I cannot prove a service was rendered because I failed to document it in the record.
7. My professional reputation is called into question because of poor written documents.

Plan of Care

A plan by whatever name is one of the basic source documents. Because the plan documents a need for service, it must be legible

and easily understood. It must contain information that agrees with and/or supplements the history-assessment forms. It confirms the need for reimbursable service and combines with the note and case review to document progress or lack of progress. Certain components are essential and exact vocabulary is demanded:

The problem statement. This must answer three questions: Why is the client here? What specific problem or problems require service? What is the specific problem for which my organization will be billing? To clarify, replace the single word *depression* with *depression caused by father's recent death*. Replace *anxiety* with *anxiety related to possible loss of job*. Replace *marriage problem* with more comprehensive information, such as *client is alcoholic who denies own role and responsibility in relationship*.

Goal statements. These questions must be answered: What are the specific aims of treatment? What specifics will result from treatment? What is the expected date of goal achievement? To clarify, replace *develop self-awareness* with *work on problem without blaming others*. Replace *become responsible* with *ride bus to and from program without others*. Replace *employment* with *apply for job with Goodwill by October 10th*.

Listing of assets. An asset helps the client achieve goals. This listing needs to include personality and emotional characteristics, community resources, and family support. To clarify, replace *family* with *supportive and understanding spouse who is involved with therapy*. Replace *money* with *client is able to work each day and has steady income*. Replace *employment* with *employment history confirms dependability, advancements, and recent pay bonus*.

Listing of barriers. Barriers hinder achievement of goals and include personality or emotional characteristics and lack of community or family resources. To clarify, replace *family* with *spouse sees client as lazy and selfish; refuses to be a part of therapy and tells client there is no value to counseling*. Replace *money* with *client recently lost job, has no income and no prospect of other employment*. Replace *friends* with *client does not like or trust people and prefers to be alone*.

Intervention or modality. This segment must answer two questions: Is it a billable service by a covered professional? Does other information within this plan clearly confirm the need for

this kind of intervention? To clarify, replace *nonthreatening support* with *abused partners group each week* or *weekly group to provide information about nature of chemical dependency as an illness.*

Clinical impression or diagnosis. This must be an accurate reflection of the client's mental health as indicated within other sections of the plan and from the data base. Spell out the full diagnostic terms and list the DSM III-R Code. Use as many axes as clinically indicated.

Review date. Include month, day, and year. Replace *1/96* with *1/10/96.*

Names and credentials. List each person who was present and participated in the development of the plan. Signatures are optional. A clear example would read *Henry Austin, Social Worker, MSSW,* or *Anna I. Smith, Psychiatric Nurse, RN.*

When completing the plan of care, be sure to record the name of the counselor designated as responsible for service delivery and the full date the plan was developed. There should be a signature of the person who wrote the plan. The signature of the physician or psychiatrist who assumes responsibility for overall client care may also be necessary, depending upon laws in your state or your agency policies. It is essential that accurate information be provided to payers. (An actual plan of care is reviewed and revised in the Evaluation of a Plan of Care section.)

Case Review

The case review is a process by which a plan is updated. The content of a review must be as comprehensive as the plan that is being examined. The components of a review are the same as a plan. Generally speaking, a plan, initial or updated, is reviewed "as clinically indicated" or as often as your state requires it.

Staff Notes

Staff notes should be written at the time of the visit. All staff notes should be recorded in chronological order and be dated and titled. The note is always signed with name, degree, and profession. Consider writing a note during the individual or group interview and use it as a means of immediate feedback with

clients. They may appreciate it. This sharing concept also permits more client involvement and requires the counselor to be more specific. Some clinicians may think, "Oh with my paranoid clients, I could never do anything like that." There may be cases where you cannot, but keep this option open.

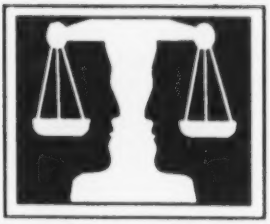
Remember that working to clarify diction—using the right words for the right purpose—is as important for staff notes as it is for other entries. The effective staff note accomplishes five defined tasks:

1. **Confirms a specific service**. In language, it is the verb that identifies most concretely the action taken. So use a strong, active verb to answer the question, "What did you do?" You *observed, questioned, identified, encouraged, reassured, instructed, informed, structured, advocated, interpreted, assessed, recommended, assisted, evaluated, prompted,* or *referred.*
2. **Connects service to key issues**. A partial listing of such issues, represented by key topic nouns in the sentences, includes *guilt, aggression, alcoholism, relationships, anger, debts, isolation, rejection, death, fears, drugs, nutrition,* or *self-image.*
3. **Confirms client response**. Again, strong verbs should be used, such as *clarified, revealed, acknowledged, demanded, resolved, accomplished, resisted, avoided, worked through, projected,* and *followed up.*
4. **Describes client's status**. Specific adjectives are needed here, such as *nonverbal, withdrawn, angry, manipulative, argumentative, unkempt, agitated, suicidal, delusional,* and *hostile.* Clarify these adjectives by adding observable behaviors.
5. **Provides directions for ongoing treatment**. At the end of every session with a client, a counselor must make some decisions with the client about where the treatment is heading. These decisions must be entered to assure continuity regardless of who sees the client next.

In all tasks, continue working to make your language as useful as possible. Some suggestions of alternatives for wording from some actual staff notes might be helpful here. To clarify, replace *we discussed relationships* with *we discussed client's problem with maintaining a relationship because of his need to dominate and control.* Replace *client was active in session, seems to be making progress* with *client was concerned about not being able*

to deal with anxiety related to possible reconciliation with spouse, was able to recognize the need for sobriety as a starting point.

The cliché goes that a picture is worth a thousand words, but in clinical documentation, there are no pictures. As playwright Samuel Beckett says, "Words are all we have." Luckily, the combinations of words available to use are endless. You do not have to be another Hemingway, and you are not required to write a volume. But, like Hemingway, you, too, are a professional who must rely upon words to document your judgments and interventions.



Analysis of a Group Note

Two problems that appear consistently in analyzing the effectiveness of the group note are the same ones mentioned in the Analysis of a Staff Note section: verifying reimbursable services and documenting professional judgments and interventions. But an additional problem exists when a note reflects service to two or more clients: The counselor must now document group process, individual client responses, and multiple interventions. Reviewing the following group note and then suggesting strategies for revision will illustrate:

AB evidenced speech problems, but was no other particular problem in group.
CD engaged in clay work.
EF was very quiet and no problem today.
GH states he lives near school. He is very bored this summer. He has been playing second base on the baseball team, and his team is in second place. He is very interested in sports. He states he tries to balance on the front and the back bike tire and do a lot of tricks. He has a younger brother and sister at home and has been helping his family build an above-ground swimming pool. This means putting 1 ton of sand in place for a foundation.
IJ showed me her hurt finger. She states that KL threw a toy at her. She busied herself by drawing pictures.

KL states that he has no friends at all. He plays with his dog. He is supposed to go and visit Dad tomorrow and thinks he will have a surprise waiting when he goes.

MN was very easily stimulated. He was making noises constantly, he was very difficult to control in group. He played in the sand.

OP was constantly moving chairs about the room. She could not sit still, had a very short attention span, and she was stimulating MN and getting into trouble most of the time.

QR wrote her name on the blackboard exactly backwards. She shows major improvement over when she was here previously, in terms of her maturation.

[Signed by a counselor and a physician]

Analysis

If you were a third-party funding source who needed to verify the rendering of reimbursable services, would you pay for this activity? Remember you received nine bills—one for each child.

If you have to assume responsibility for group this week, would you know what to do? Can you name the service? Notes like this verify attendance and/or activity only. We must get in the habit of documenting our professional judgments and interventions. Does this kind of entry make us appear to be the professionals we claim to be?

AB evidenced speech problems but was no other particular problem in group. There are many kinds of speech problems. If a reader had access to other parts of the record, would this problem be defined? There are many ways that someone can provide evidence of a problem. What was the specific evidence, and more importantly, how did the therapist respond to it? What was the service for this speech problem? What is the significance of *no other particular problem*? Is this a subtle indication of progress?

CD engaged in clay work. Who cares? Why should we be provided funding because a child entered a room and was engaged in clay work? What did we do?

EF was very quiet and no problem today. These words equate to an unfounded opinion. What did EF do? Why was EF there? What was the service?

GH states he lives near school. This kind of information is usually recorded in the data base or on the face sheet. To enter

it here is redundant and unnecessary. If this information is not included in another part of the record, what is the clinical significance?

He is very bored this summer. He has been playing second base, on the baseball team, and his team is in second place. This information is conflicting and insignificant; why is it here?

He is very interested in sports. He states he tries to balance on the front and the back bike tire and do a lot of tricks. Once again, a reader will be asking about the significance, if any, of this information.

He has a younger brother and sister at home and has been helping his family build an above-ground swimming pool. This means putting 1 ton of sand in place for a foundation. The reader must be wondering, why is this here? What does it have to do with a child's group therapy session? If there was significance to any of this information, how did the counselor respond to it?

IJ showed me her hurt finger. She states that KL threw a toy at her. She busied herself by drawing pictures. I hope that by now you are getting the picture. So far we have read about five children in this group and have no idea why they were there, how they responded to one another, and what the professional interventions were.

KL states that he has no friends at all. He plays with his dog. He is supposed to go and visit Dad tomorrow and thinks he will have a surprise waiting when he goes. The lack of friends and the visit with his father could be very important; elaborate on this kind of material.

MN was very easily stimulated. He was making noises constantly, he was very difficult to control in group. He played in the sand. What does *easily stimulated* mean? What control measures were employed by the counselor? The physician? Other group members? What is the significance of playing in the sand?

OP was constantly moving chairs about the room. She could not sit still, had a very short attention span, and she was stimulating MN and getting into trouble most of the time. Did the moving of chairs have clinical significance? If yes, what? If no, why write it? Was the short attention span addressed? How was she stimulating MN?

QR wrote her name on the blackboard exactly backwards. She shows major improvement over when she was here previously, in terms of her maturation. Age information is usually listed in

other parts of the record; why repeat it? Each time you can save one or two words, do so. How did QR write her name on the previous visit? How is this a major improvement?

Someone wrote 250 words and yet the information conveys nothing other than that these children were in a group.

Although two signatures were entered, can a reader assume that both professionals were in the group for the full time? This could have significance in terms of verifying reimbursable services. Does a physician's signature indicate supervision or participation or both? Signatures must clearly indicate whether the counselor was the service provider and the physician was the supervisor, and whether both the counselor and physician were present during the session.

How long did the group last?

Rewrite

Group: 90 minutes (date)
Present: AB, CD, EF, GH, IJ, KL, MN, OP, and QR
Overview: As planned last week, session focused on sharing things and expressing anger. Four children chose their favorite item in the playroom and were instructed to share it with one of the other four who were instructed to play a personality of their choice. Later, roles were reversed. Then we discussed feelings and how feelings differed according to personality types. Everyone participated with exaggerated acting. A spontaneously organized Oscar ceremony concluded the session.

The above entry is photocopied and placed in each child's record. However, before each page is filed, the counselor must also write an individual note pertaining to each child for insertion into that child's chart.

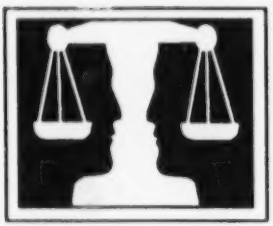
For example:

- AB said he was embarrassed by stuttering, but with group encouragement, he participated in role playing. For the first time, he became so involved that his speech problem disappeared.
  Signed: Counselor and Physician

- CD was able to engage with EF in clay work. Each one tends to isolate herself, but today they participated with one another's support. Each said she was "scared" to act in front of others, but they did participate, and their Oscars provided impetus for their first laugh with the group.
  Signed: Counselor and Physician
- IJ and KL were so involved in their role playing that KL, in anger, threw his toy at IJ. Their altercation generated the most group discussion; everyone agreed that anger is a difficult emotion to deal with.
  Signed: Counselor and Physician

Notice the major features of the rewrite:

- The total group time and date of session are given first.
- A list of clients in the group is given, using initials for confidentiality purposes and assuming complete names are given in the client's individual record.
- Details were added where necessary to provide a reader with information that specifically refers to the counselor's intervention.



Evaluation of a Plan of Care

A plan of care must clearly identify a client's problems, the interventions to be provided, and the anticipated results of our interventions. Following is the text of an actual plan. Also included on the form, which was dated and signed, were the client's name and identification number.

Client strength: Motivated for therapy.

Problem 1: Chronic, undifferentiated schizophrenia.
Short-term goal: Maintain remission.
Long-term goal: Increase coping ability.
Method: Explore ego-syntonic coping abilities.

Problem 2: Low self-esteem, poor self-image.
Short-term goal: Better sense of self.
Long-term goal: Self-esteem.
Method: CMI Group and Ind. AOS therapy.

Problem 3: Independent living.
Short-term goal: Self-assessment of needs.
Long-term goal: Problem anticipation/solving skills.
Method: Daily diary of experiences, dreams analysis, and reflection on pleasant events.

Analysis

What does *motivated for therapy* mean? Eliminate doubt with an entry such as *keeps appointments* or *follows through on assigned tasks.*

Problem 1 is a diagnostic category, not a problem. What is the meaning of *maintain remission*? If the client said, "Watch me maintain remission," what would we see or hear? What is the meaning of *increase coping ability*? If the client said, "Watch me increase my coping ability," what would we see or hear? How are we going to explore *ego-syntonic coping abilities*?

Problem 2 must be explained. Will a reader know how the writer concluded that the problem is *low self-esteem*? The long- and short-term goals are basically the same. If the client said, "Watch me have a better sense of myself" or "Watch me increase my self-esteem," what will he or she be doing differently?

Problem 3 *Independent living* is not a problem. Furthermore, the methods listed may not be reimbursable. A plan must verify a need for the kinds of services for which you will be billing. Why should anyone fund us because a client is keeping a *daily diary of experiences*? Short- and long-term goals are vague. If the client said, "Watch me anticipate my problem anticipation and solving skills," what behavior will result? Or, if the person said "Watch me reinforce my self-esteem," what behaviors would be observable and measurable? Vague, generalized statements are of no value.

Special note: Many promotional brochures advise the public that services are individualized and developed by a multidisciplinary team. If that is promised, records must verify it. This plan, for example, contained no information to indicate that anyone other than a counselor was involved. A plan should list the names and professions of the individuals who developed the plan of care.

Rewrite

Client strength: Keeps appointments.

Problem 1: Noncompliant with medications.
Short-term goal: Take medications as prescribed.
Long-term goal: Remain in community for 12 months without readmission to hospital.
Method: Weekly support group for persons in supervised apartment, monthly medication monitoring group, and individual therapy per request.

Problem 2: Nightmares about losing job.
Short-term goal: Keep scheduled appointments for next 8 weeks.
Long-term goal: Verbal reports of restful sleep (8 hours each night).
Method: Individual therapy with emphasis on recognizing strengths.

Problem 3: Wants own apartment but doesn't earn enough. Must live with parents who don't want him in their home.
Short-term goal: Keep his job and set up appointment with vocational rehabilitation office within 6 weeks.
Long-term goal: Participation in vocational rehabilitation program within 8 months.
Method: Same as for problem #2.

The reader will know from this plan of care why the client is seeking counseling and what is going to be done.

Confidentiality and Other Legal Issues

Throughout the preceding sections, the emphasis has been on preparing clear and comprehensive records to avoid legal complications. But sometimes the worst-case scenario does occur, and legal challenges to our records are entered. In this section, we review some legal issues and ways to anticipate and deal with them if they arise.

We must be constantly aware of risk management and loss prevention principles, but don't be overwhelmed with worry and anxiety. We can learn to balance paranoia with common sense. Common sense tells us we cannot ignore the reality surrounding us, and the reality is this: If you are accused of wrong doing, there will be emotional costs for you, administrators, other employees, family members, and friends. Remember, your words (or lack of words) could be the basis for a judgment against you. Do not provide ammunition to the plaintiff's attorney. The opposition's goal is to establish credibility, even if it requires the destruction of your reputation. The validity of your records will be challenged, and information will be reviewed with a fine-toothed comb. An attorney will aggressively attempt to educate a jury with evidence you could unwittingly provide in the form of inconsistencies in the record. More than once, agency "guilt" has been established by effective, although negative, use of the record.

Every legal method will be used to obtain documents that may support the malpractice claim. It will be important for you to be able to show you acted in good faith, within the scope of your job function and in compliance with your internal standards of care. This is another interesting area because it relates to personnel and to policy manuals. Your agency will have established the foundation for a viable defense if you have paid attention to the following:

- Job descriptions are clear.
- Personnel evaluations are done on a regular basis.
- Personnel evaluations are more than a "friendly" talk.
- Meaningful personnel records are current.

Personnel records are discoverable in that attorneys will have access to them in preparation for a trial. The contents of personnel records could be admissible evidence, depending on the nature of the case. Based on information obtained from the personnel file, an attorney may attempt to convince a jury that the practitioner was irresponsible or not qualified. The attorney could also attempt to establish agency irresponsibility by showing failure to terminate incompetent personnel. It is wise to consider reference checks and criminal record checks especially when hiring direct service staff.

Although it is true that a client must prove a claim, juries have been sympathetic with clients. One reason for a jury's sympathy is the lack of sufficient documentation within service records, personnel records, and policy manuals.

Sufficient documentation begins with a signed permission-to-treat form. However, having the signature may not be enough if the client has been declared legally incompetent or is too young. The length and complexity of forms can also be detrimental. For example, an attorney may attempt to show that the client could not have been aware of what was being signed because forms were too confusing for a troubled person to understand or because the implications of those forms were not fully explained. Your best defense is to clarify legal concerns *before* treatment.

When a client will not sign a permission-to-treat form, he or she should be requested to sign a statement that documents the refusal to sign. When a patient will not sign the refusal form, the refusal should be documented, witnessed, and signed by both the practitioner and the witness. The best witness is a family

member or relative. The least satisfactory witness is a co-worker. When an individual requests service and is seen for assessment but then decides not to become involved in ongoing treatment, the session and outcome should be documented by the practitioner. In such cases, documentation and witness signatures can be very important. If the person leaves the site and does harm to self or another, the agency is in a vulnerable position. Should a lawsuit result, the lack of documentation could equate to abandonment.

A plan of care is of the utmost importance in providing sufficient documentation because it establishes the foundation for subsequent entries. Any deviation from the plan creates an area of vulnerability unless a record clearly explains changes.

When a case is closed, the client should be notified, and the notification should be documented. When a client cannot be located, consider notification through a friend or family member. When an agency concludes that a friend or family member should not be notified or when the agency is unable to locate the client, the decision not to notify or the inability to notify should be documented. A termination summary must be timely and accurate. The content should clearly establish the fact that discontinued service will not be harmful to the client's health or behavior.

Sufficient documentation may also include some changes. Although every attempt should be made to avoid changes, if you must make a change, do not obliterate the previous entry. Using ink, draw a single line through the words, date it, and add the word *error*. Then add the information you wish to include, label it *corrected entry*, sign it, date it, and cross reference it to the original entry.

Follow directions on your forms. Do not leave blank spaces; they create doubt.

The most frequent reasons for a malpractice suit are negligent treatment, failure to diagnose, sexual allegations, and the aftermath of suicides or attempted suicides. I recently asked a lawyer and a psychologist to comment on the idea of "It's best to be vague. If you are too specific, they will pin you to the wall." The lawyer's response was that a record should contain any information that is needed for treatment and continuity. It is better to be complete than incomplete because if you or another must rely upon or explain an entry (yours or someone else's) you may

not be able to do so. She also added that if you are on the witness stand, do not speculate. If you do not know, say so. The psychologist recalled a difficult case he believed just might end up in court. A custody settlement decision, he thought, could be based on his record and testimony. His intuition was correct and he did end up in court. He also remembered feeling secure and prepared for his court appearance because the documentation was thorough, precise, and current.

Appearances in Court

An appearance in court will create anxiety. You're not going to walk in and wow them. You're not even going to get top billing; you're on someone else's turf. To be prepared, observe the following tips:

1. Have your credentials typed and ready. List all honors, publications, special recognitions, licenses, certifications, training. Be aware of overkill because this type of presentation can have a reverse effect. Nevertheless, be confident and proud of the professional that you are and the job that you do. Let them know in no uncertain terms why you should be listened to.
2. Do not voluntarily take a record to court. Your only obligation is to provide records specifically ordered by a court of the appropriate jurisdiction.
3. Take as much time as you need to answer questions. If you do not believe you are permitted enough time, turn to the judge and say, "Your Honor, I'd like to elaborate on that point."
4. Realize that many areas of law are still developing. No one can give you all the right answers. Make sure you have competent legal representation. This point is covered in the first monograph in this series, Remley's *Preparing for Court Appearances*.

Confidentiality

Even though clients' records could be made public, the right to confidentiality is still basic and must be safeguarded by the

practitioner. The following is a list of everyday things we can do to protect the privacy of our clients' lives:

1. Do not leave charts or management information reports on your desk or in areas where they can be read by anyone.
2. Do not carry on conversations in hallways or other public areas where persons who do not need to know can hear.
3. Do not post individual client names or group member names in a place where anyone and everyone has access.
4. Know what is going on in your offices. Are records being taken home? Kept in offices for extended periods of time? Are duplicate copies being made and circulated? Establish and adhere to internal policies about access to management reports and counseling records.
5. Use plain white envelopes rather than organizational stationery with logos when communicating with clients.
6. Be aware of your client's feelings about being recognized by name. I recall meeting a client at a basketball game and calling him by name. He was pleasant that evening, but the next day he came to the office and read me the riot act. I was never again to call him by his name in a public place because he did not want family or friends to associate him with a mental health professional.
7. Do not keep a "secret" chart for your own use. Not only is it unethical, but that kind of documentation has an uncanny way of finding its way into courtrooms and other public places. In addition, it's more paper work for you! And if you ever appear in court to say you have no other records, you have perjured yourself. At the same time, if a judge or jury is provided with the official record, and it is filled with vague or incomplete entries, an interpretation is likely to be negative.

Special note: *Confidentiality*, in general terms, means maintaining the secrets of patients and clients. The concept goes beyond the record and covers communication between the patient and the counselor. The purpose of confidentiality is to encourage candor so that the client will yield more thorough information, thereby promoting better diagnosis and treatment. Confidentiality of records also encourages candor in counselors, so that the patient's record is written with service delivery, rather than liability or diplomacy, in mind.

In legal proceedings, the concept of privilege, a rule of evidence, protects the professional from being compelled to testify about confidential communications with a client. Because claims of privilege thwart the search for the truth, however, courts disfavor such claims. Also, privilege, like confidentiality in general, exists for the benefit of the client and so can be waived by the client. Most important, if a client sues an agency for malpractice, then he or she automatically puts his or her condition at issue and so waives any claim of privilege to the treatment records.

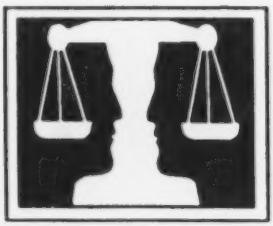
It is important that the agency develop a policy of records retention and follow that policy without exception. Many facilities have a policy of maintaining all records for 5 years. You should note that if persons under the age of 18 are treated, they may sue for malpractice once they reach the age of majority, regardless of how many years after treatment that might be. If those client's records were destroyed following an established policy, however, the agency should not suffer adverse consequences.

Some Final Comments

"I'd rather have a good chart than anything else," says an attorney discussing what he needs to defend a malpractice suit. A survey published in the *Michigan Bar Journal* found that judges—85%—and lawyers—80%—prefer clear writing and simple, direct language. They also like strong verbs, short sentences, and use of first person. They do not like archaic words, abstract nouns, long sentences, hard-to-understand phrases, third-person and negative forms.

This kind of clear writing in records has been the focus of this monograph. Laws change daily and regulations differ from state to state. We can talk only about risk management—not risk elimination. When in doubt, discuss the issue with an attorney.

In closing, I must stress the need to think optimistically. Remember: The person who can smile when things go wrong has thought of someone who can be blamed. Make sure that someone isn't you.



Frequently Asked Questions

Q. Is too much being made of this issue of documentation?

A. No. Your written words in the records or in letters of correspondence are a reflection of your professional identity and the organization for which you work. Good documentation confirms good practice. Further, it is the courts and third-party payers who have made the issue of documentation a serious one for counselors.

Q. Will recording information as suggested in this book "trivialize" my record?

A. A record is not yours alone. It is a document for use by you and anyone else who may be required to see a client in your absence. If you believe specificity will trivialize your entries, this monograph will probably not change your mind. Nevertheless, it is my contention that usefulness requires specificity.

Q. Counseling is difficult to describe and results are often intangible. How can I tell a reader all of the things I did?

A. You probably do not need to let someone know everything you did. Usually, a strong verb will let someone know the type of service you provided. A partial listing of words includes:

advised
assessed
assisted
clarified
confronted
counseled
discussed
directed
encouraged
focused
identified
interpreted
reassured
recommended
referred
reflected
stabilized
structured
supported
urged

Q. What words are *conclusionary*? And what does it mean?

A. Any word or phrase that is not explained is conclusionary. Conclusionary words should be avoided in records. Most often it is an adjective or an opinion such as:

abnormal
abusive
adamant
anxious
apathetic
dangerous
delusional
demanding
dependent
disruptive
disturbed
helpless
hysterical
immature

impulsive
irrational
lonely
overwhelmed
resistive
tense
tenuous
threatened
troubled
uncooperative
unfit
unrealistic
unresponsive

Q. I have difficulty writing measurable goals. What do you suggest?

A. To provide more specificity, insert the phrase *watch me be . . .* in front of your goals and read them aloud. Consider which of the following sets of phrases is more useful:

Watch me be positive
Watch me be appropriate
Watch me be independent
Watch me be mature
Watch me be cooperative.

Watch me keep my appointments
Watch me listen without interrupting
Watch me move into an apartment
Watch me register to vote
Watch me prepare one meal per day.

Q. How important is the termination process and the closing summary?

A. Every aspect of the counseling process is important. Clients must be actively involved in each phase of service, inclusive of termination. Here are some documentation guidelines:

- Note the factual basis for termination.
- Make reference to previous discussion about closure.
- Document each effort to contact the client after broken or missed appointments, especially if the clients is in a high-risk category.
- Provide the client with a plan of action, inclusive of community resources.
- If you are unable to discuss closure with the client, write a letter that is courteous, caring, sincere, and professional. Do not reveal feelings of frustration or threaten action pertaining to unpaid bills.

Q. Should I write my notes in the first person or in the third person?

A. Follow your agency's policies. If there are no guidelines, write in a style that is clear and comfortable. My preference, as you have noticed, is the first person. However, my first job required me to write all entries in the third person (i.e., *Social worker said . . .* or *Social worker did . . .*)

Q. Could you comment on sex-bias wording?

A. The first thing to do is to keep an awareness foremost in your mind, especially in terms of writing reports or letters to other organizations. Here are a few ideas:

- Write *big job* instead of *man-size job.*
- Write *employee* instead of *workman.*
- Write *average person* instead of *the common man.*
- Write *personnel* instead of *manpower.*
- Write *professional* instead of *career woman.*

Q. My client has AIDS but does not want anyone to know. What should I write in the record?

A. There is not much legal guidance in terms of what to document. We should probably lean toward protecting our client's right to confidentiality, but only you can decide on a case-by-case basis. You should ask yourself, "What is the purpose of this note/record?" The fact that you do not write what you know does not take away the fact that you know or suspect something. Problems down the road will usually result from failure to doc-

ument rather than what has been entered. Unfortunately, whichever way you go, you may be simply deciding what type law suit you want to be able to face/defend.

Q. I do not have enough time to write. What can you suggest to save time?

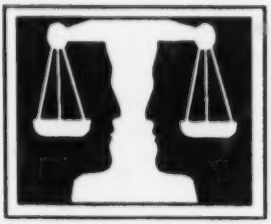
A. Read this book carefully. Involve your clients in actually writing notes, plans, and reviews. In that way when the session is finished, so is much of your charting. Eliminate unnecessary words. Consider using, for example:

consistent instead of *uniformly consistent*
except instead of *with the exception of*
probability instead of *in all probability*
throughout instead of *throughout the entire duration of*
can instead of *possesses the ability to*
each instead of *each and every*
April instead of *the month of April*
because instead of *in view of the fact.*

Admittedly, adopting more specific writing procedures may take more time at first, but practice will make it easier and quicker.

Q. Aren't most record entries an accurate reflection of professional service, and aren't the examples used in this monograph exceptions?

A. Unfortunately, no. The examples used represent the rule rather than the exception in the records of hundreds of organizations reviewed during the last 10 years. Good counseling service requires good documentation. It is my hope that this monograph will help you write with pride.



Summary

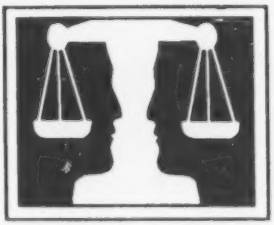
This monograph is intended as a reference, focusing on practical information and offering guidelines for accountable documentation within counseling records. It is not intended to replace competent legal advice and does not claim to provide a bulletproof system of record keeping. Nevertheless, your entries are important in establishing your credibility as a professional. Counseling records must provide honest, accurate, understandable, relevant information in order to ensure:

- continuity of care if you are seeing a client or if someone else must provide service in your absence
- verification of reimbursable services to assure cash flow and the elimination of payback to third-party payers
- reliable information for the counselor's defense in the event of a malpractice suit
- reliable information for the court's use in making decisions in controversial issues, including child abuse and parental rights.

As the first monograph in this AACD series points out, most readers will not be sued for malpractice, but each year more counselors are finding themselves reluctantly involved in a court proceeding. Probably you will not have done anything "wrong,"

but you will have records and knowledge that are relevant to the court's concerns.

So let us be prepared, and let our records show the world we are competent. This monograph is intended as a practical guide in demonstating that competence.



Discussion Questions

1. Consider the validity of the following statements:

a. Paper work has nothing to do with the quality of service and/or the outcome.
b. Generally speaking, a long note is better than a short one.
c. Confidentiality laws will protect my documentation. The information a client shares is strictly between us.
d. It is best to be vague. If you are too specific, they'll pin you to the wall.
e. In "sticky" situations, it's best to keep a separate chart with my private notes and impressions.
f. Every note must document progress.
g. To be on the safe side, it's best to use a lot of qualifiers such as *seems* and/or *appears*.
h. Counseling records are as important to an organization as the ledgers in the accounting department.

2. Circle the clearest wording of a problem statement:

a. court referral
b. anxiety related to possible loss of job

c. depression
d. referred by hospital.

3. Circle the clearest wording of a goal objective:

a. Eliminate inappropriate behaviors.
b. Brush teeth and shower each day.
c. Improve levels of functioning.
d. Increase level of independence.

4. Circle the words that are self-explanatory:

a. chronic
b. delusional
c. denies hallucinations
d. flat affect
e. hostile
f. immature
g. inappropriate
h. psychotic
i. violent behavior.

5. Circle the factors that could influence the credibility of a record:

a. format
b. legibility
c. overall appearance
d. spacing.

6. Circle the most frequent causes for malpractice suits:

a. sexual allegations
b. suicide attempts
c. failure to diagnose
d. negligent treatment

e. poor record keeping
f. rude behavior
g. failing to return phone calls
h. making promises that can not be kept.

References and Suggested Readings

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NOTES

"I applaud Dr. Remley and AACD as well for the idea of a series of monographs in dealing with legal issues that will help mental health professionals and counseling students."

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